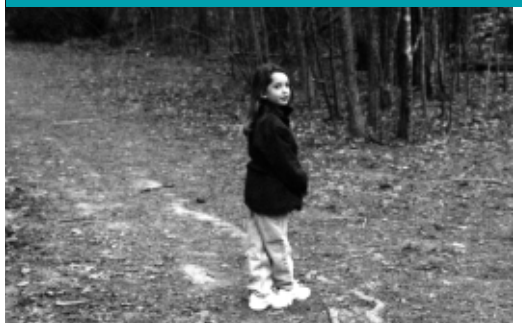


THE BEST WAY TO EXPLORE THE FUTURE IS TO **CHOOSE THE PATH TO BETTER HEALTH.**

NORTH CAROLINA'S COMPREHENSIVE PLAN TO PREVENT AND REDUCE THE HEALTH EFFECTS OF TOBACCO USE

Vision2010

contents

THE BEST WAY TO EXPLORE THIS PLAN

THE BEST WAY TO EXPLORE THE FUTURE IS TO **CHOOSE THE PATH TO BETTER HEALTH**

NORTH CAROLINA'S COMPREHENSIVE PLAN TO PREVENT AND REDUCE THE HEALTH EFFECTS OF TOBACCO USE

acknowledgments

THIS PUBLICATION WAS PREPARED THROUGH THE COLLABORATIVE EFFORTS OF THE FOLLOWING LEAD CONTRIBUTORS:

THE LEAD CONTRIBUTORS wish to thank all the people who served on work groups and task forces and/or reviewed draft segments of this document. For a complete list see appendix IV.

The Tobacco Prevention and Control Branch wishes to thank all the local health directors who completed a survey that contributed data to the development of this document.

The contributors wish to acknowledge the Centers for Disease Control and Prevention for their publication *Best Practices for Comprehensive Tobacco Control Programs*.

Finally, the contributors wish to thank Alyssa Hogan, 6, Chapel Hill—our enthusiastic model cover girl!

MARGARET BRAKE
NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services

CHUCK BRIDGER, MA
American Cancer Society, Southeast Division

DEBORAH BRYAN, MEd
American Lung Association of North Carolina

FRED CHARLES
MediaSmartz

PAULA COLLINS
NC Department of Public Instruction, Healthy Schools Initiative

SANDRA COLT
NC Division of Public Health, Tobacco Prevention and Control Branch

SARAH COX
NC Prevention Partners

GEORGE CRAWFORD, MPH
Mecklenburg County Public Health Department

LEAH DEVLIN, DDS, MPH
NC Division of Public Health, Health Promotion, Disease Prevention Section

JOE DUGDALE, JD
NC Division of Alcohol Law Enforcement

CLAUDIA EGELHOFF, MPH
American Cancer Society, Southeast Division

BILL FURNEY
NC Department of Health and Human Services Office of Communications

MARY GILLETT, MS
Guilford County Department of Public Health

ADAM GOLDSTEIN, MD
UNC School of Medicine

LISA MARIE GUSTOFSON
NC Prevention Partners

SANDRA HEADEN, PHD
National African American Tobacco Prevention Network

ANN HOUSTON, CHES
NC Division of Public Health, Tobacco Prevention and Control Branch

DELMONTE P. JEFFERSON
NC Division of Public Health, Tobacco Prevention and Control Branch

ARTHUR KAMIYA
Safe and Drug-Free Schools, NC Department of Public Instruction

JOHN LEAK
Consultant, Safe and Drug Free Schools, Department of Public Instruction

SALLY HERNDON MALEK, MPH
NC Division of Public Health, Tobacco Prevention and Control Branch

JIM D. MARTIN, MS
NC Division of Public Health

KATHLEEN MCCANN WEBSTER
Schools Consultant

TIM MCGLOIN, MPH
UNC School of Public Health, Center for Health Promotion, Disease Prevention

LAURIE METTAM-RUDE, MEd
NC Division of Public Health, Tobacco Prevention and Control Branch

MEG MOLLOY, DRPH, RD
NC Prevention Partners

PEG O'CONNELL, JD
NC Prevention Partners, Medical Review of NC

TRICIA PARISH WARD, MA
NC Division of Public Health, Women's and Children's Health Section

MARGUERITE PEEBLES
Alternative and Safe Schools/ Instruction Support Section, NC Department of Public Instruction

LISA POOVEY GREENE
American Cancer Society, Southeast Division

BARBARA PULLEN-SMITH, MPH
NC Division of Public Health, Office of Minority Health

KENNETH RAY, MPH
NC Division of Public Health, Tobacco Prevention and Control Branch

KURT RIBISL, PHD
UNC School of Public Health, UNC Lineberger Comprehensive Cancer Center

JIM RICHMOND
GlaxoSmithKline

LYNETTE RIVENBARK
American Heart Association

RICHARD ROSEN, MD
Private Physician

DEBORAH ROWE
NC Public Health Association

MICHAEL SANDERSON, MPH
NC Department of Health and Human Services, Healthy Schools Initiative

WILLIAM J. SMITH, MPH
NC Association of Local Health Directors

MARGARET WATKINS, MS
Appalachian District Health Department

introduction

THE PATH WE CHOOSE

NORTH CAROLINA STANDS at a crossroads. Centuries old social, economic and political traditions are giving way to the knowledge gained in recent decades about the health effects of tobacco use. At this point in time, we know more than ever before about how to save lives once lost due to tobacco use. Data from other states have shown that implementing a comprehensive tobacco use prevention and control program produces substantial reductions in tobacco use and improves health outcomes.

We have visions of new social norms—healthier newborns, tobacco-free kids, smoke-free air, and less premature death from heart disease, cancer, strokes and chronic lung disease. We have a vision of a population that sees *quality* of life as the true measurement of its success.

Tobacco use is the number one preventable cause of premature death and disease in North Carolina and the nation. It is estimated that 21 percent of the deaths in our state are associated with tobacco use—more than 14,500 in 1999. North Carolina's young people are using tobacco at increasingly alarming rates; 38% of our high school students and 18% of our middle school students currently smoke, dip or chew.

Our overall success in improving the health status of North Carolinians thus depends greatly on achieving dramatic reductions in the rates of tobacco use among both adults and young people. To succeed, programs and policies must address the needs of North Carolinians of all ages and racial, cultural, and ethnic backgrounds.

Regarding states' investment in comprehensive tobacco control programs, Dr. David Satcher, U.S. Surgeon General recently said, "Not since the polio vaccine have we had such a tremendous opportunity to reduce death and disability in this country."

The Centers for Disease Control and Prevention (CDC) recommends that each state establish a tobacco use prevention and control program that is comprehensive, sustainable and accountable. The CDC publication entitled, *Best Practices for Comprehensive Tobacco Control Programs* states that $42.5 million is the minimum total annual funding needed for a comprehensive program in North Carolina. A sizable investment, over a long enough period of time, will assure that the program described in this document will save North Carolina lives and North Carolina dollars.

WHAT YOU ARE HOLDING in your hands is a map designed to help guide us down the path to a healthier future. *North Carolina's Comprehensive Plan to Prevent and Reduce the Health Effects of Tobacco Use* describes a multiple strategy approach that involves a range of coordinated tobacco use prevention strategies that reinforce each other in a synergistic fashion. This strategic plan relies heavily on the guidelines provided by the CDC, but tailors that national strategy to North Carolina. In this document you will find the framework for effective programs and policies needed to reduce the serious burdens of disease, disability and death related to tobacco use. The comprehensive tobacco use prevention plan focuses on four goals:

- ❑ Prevent the initiation and promote quitting of tobacco use among youth;
- ❑ Eliminate exposure to environmental ("secondhand") tobacco smoke;
- ❑ Promote quitting among adults; and
- ❑ Eliminate disparities by improving the health-related norms of vulnerable and underserved racial, ethnic, and income groups more adversely effected by tobacco use.

> **"NOT SINCE THE POLIO VACCINE HAVE WE HAD SUCH A TREMENDOUS OPPORTUNITY TO REDUCE DEATH AND DISABILITY IN THIS COUNTRY."**
>
> DR. DAVID SATCHER
> U.S. SURGEON GENERAL

"When you look at the evidence from other states, there is clearly a dose-response relationship; states that are adequately funded are showing progress in reducing tobacco prevalence and consumption, those with less than adequate funding are not. Given this, withholding this kind of comprehensive program from the citizens of North Carolina would be like withholding treatment from a patient that is known to be effective," said John Morrow, MD, MPH, Chair, Public Health and Substance Abuse Prevention Committee, North Carolina Medical Society.

Protecting and promoting the health of everyone will help North Carolinians live longer, be more productive and have happier lives. To address this concern, the state needs to reduce the use of tobacco products and the exposure to environmental tobacco smoke. The state needs to help adults who wish to quit using tobacco so they can become positive role models for our children. The state must address the health disparities among certain ethnic and minority groups as well as underserved populations such as low socioeconomic groups in both urban and rural settings.

"My hope is that we will be able to look back some years from now and be able to measure our contribution to the nation's long-term health by what we do with respect to the tobacco issue today and in the immediate future," said James S. Marks MD, MPH, Director of CDC's National Center for Chronic Disease Prevention and Health Promotion.

The plan lies within these pages. Opportunity calls. Now is the time to choose our path to the future.

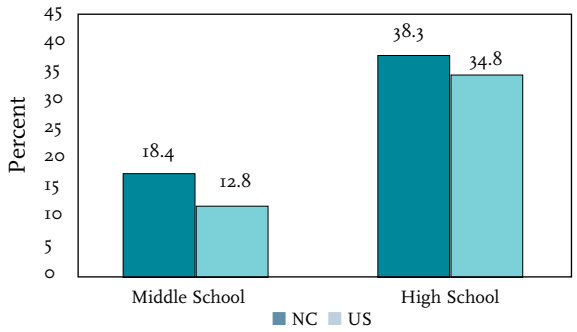
TOBACCO USE IS the number one preventable cause of premature death and disease in North Carolina and the nation [*NC Department of Health and Human Services, 2000, Centers for Disease Control and Prevention, (CDC) 2000*]. Smoking causes more than 14,500 annual deaths in North Carolina, which accounts for 21 percent of the total deaths in our state (*NC State Center for Health Statistics, 2000*). Nearly 96 percent of lung cancers among men and 92 percent among women in the US were caused by active smoking, making male smokers 23.2 times and female smokers 12.8 times more likely to die of lung cancer than nonsmokers (*CDC, 1999*).

In fact, smoking causes more deaths than the combined total of people who die from alcohol, AIDS, car crashes, illegal drugs, murders and suicides. Thousands more die from other tobacco-related causes, such as exposure to secondhand smoke (more than 40,000 deaths per year nationwide), health consequences of spit tobacco use, and fires caused by smoking (more than 1,000 deaths per year nationwide). In North Carolina, it is estimated that each smoker loses an average of **14.7 years of life** due to smoking. The most recent state estimates available place NC smoking-attributable costs for medical care at $1.2 billion in 1993, (*CDC, 1999*).

Despite this, twenty five percent (25%) of adults, ages 18 and older, smoke (*Behavioral Risk Factor Surveillance Survey, BRFSS, 1999*). Spit tobacco is predominately used by white males—**6.9 percent** of white males reported using spit tobacco (*BRFSS, 1997*). In the U.S., 37% American Indians smoke as compared to 25.7% African Americans, 25.1% White, 19.7% Hispanic and 15.3% Asian (CDC,2000).

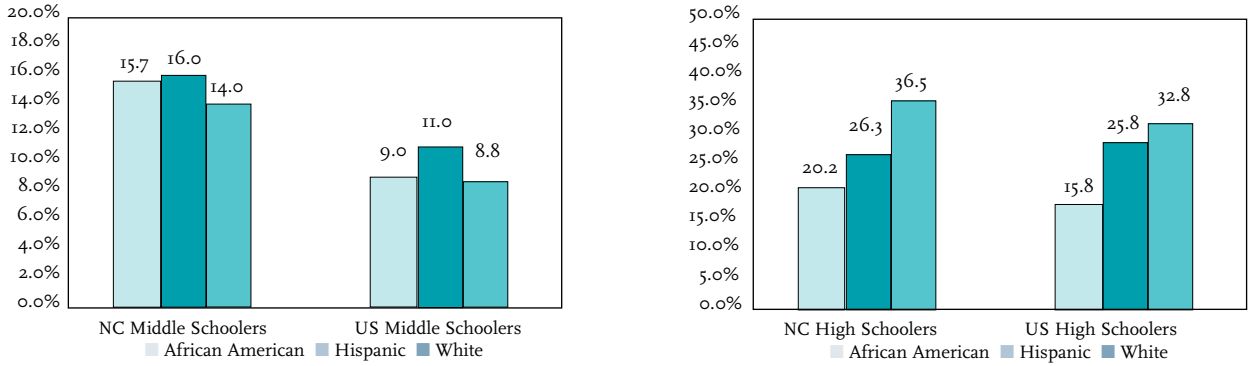
Tobacco use (including cigarette, cigar and spit tobacco use) almost always begins in the teen years. In fact 90 percent of current smokers start before age 20 (*CDC, 1999*). Teen tobacco use rates have increased in North Carolina during the last six years. An alarming **38.3 percent** of North Carolina high school students and **18.4 percent** of middle school students are current tobacco users. Youth from rural areas are more likely to report tobacco use than teens in urban settings, 41.2% vs. 35.2% (*NC Youth Tobacco Survey, 1999*). As shown in Figure 1, tobacco use rates among NC high school and middle school students are above the national rates.

FIGURE 1. CURRENT TOBACCO USE RATES COMPARING U.S. AND N.C. STUDENTS*



Source: National Youth Tobacco Survey (YTS) and NC YTS, 1999

FIGURE 2. CURRENT* CIGARETTE SMOKING AMONG MIDDLE SCHOOL AND HIGH SCHOOL STUDENTS BY RACE AND ETHNICITY

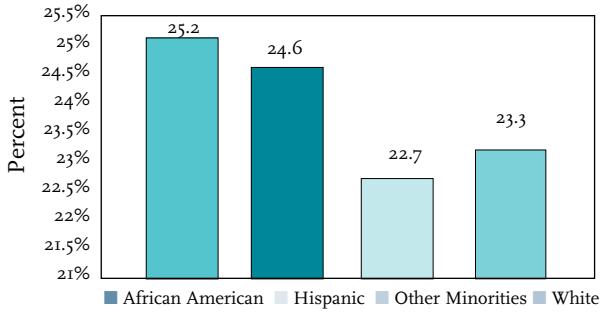


*Used cigarettes on one (1) or more of the past 30 days preceding survey
Source: National Youth Tobacco Survey (YTS) and NC YTS, 1999

CURRENT* CIGARETTE SMOKING ADULT — 1999 BRFSS

North Carolinians are more likely to smoke than their counterparts in the United States, 25 percent versus 23 percent. Only ten states report a larger percentage of adults smoking than NC. The chart below shows current adult smoking rates by racial group in North Carolina.

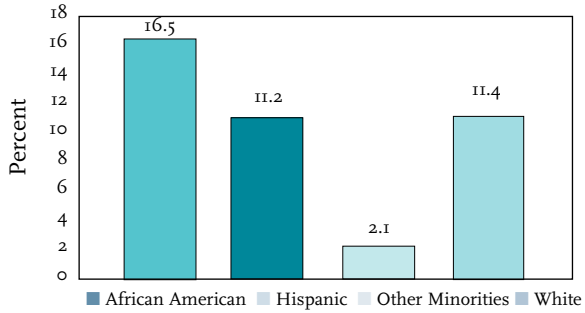
FIGURE 3. CURRENT* CIGARETTE SMOKING AMONG ADULTS (Ages 18 & older)



Source: State Center for Health Statistics (SCHS), 1999
Behavioral Risk Factor Surveillance Survey (BRFSS), 1999
NOTE: The category of "Other Minorities" may include Native Americans and Asian Americans.

In 1998, 15.2 percent of pregnant females reported to be current smokers. Smoking among pregnant women leads to low birth weight, a leading cause of infant mortality.

FIGURE 4. CURRENT SMOKING AMONG PREGNANT FEMALES BY RACE AND ETHNIC GROUP*



Source: State Center for Health Statistics. Vital Statistics—Birth Certificate Data, 1998.
NOTE: The category of "Other Minorities" may include Native Americans and Asian Americans.

ADDITIONAL FACTS

FORTY-FOUR PERCENT (44%) of high school students and 33% of middle school students are considered susceptible to begin tobacco use within the year (*NC YTS*, 1999).

ENVIRONMENTAL TOBACCO SMOKE or "secondhand smoke" is a known human lung carcinogen and a serious health threat to children and adults (*Surgeon General's Report*, 2000).

ALMOST HALF OF NC middle school students (48.8%) and high school students (46%) live with someone who smokes (*YTS*, 1999).

IN NORTH CAROLINA, as in the rest of the U.S., the leading causes of death for African American males are heart disease, cancer, and stroke (NC State Center for Health Statistics). Smoking and other forms of tobacco use are major contributors (*CDC—Chronic Disease in Minority Populations*, 1994).

NORTH CAROLINA government's annual Medicaid payments directly related to tobacco use is estimated at $200 million. (*L. Miller et.al., "State Estimates of Medicaid Expenditures Attributable to Cigarette Smoking, Fiscal Year 1993," Public Health Reports, 113:140-151 (March/April 1998*).

Minors' Access to Tobacco Products (G.S. 14-313)

Minimum age for sale: 18

Penalties: Any person who gives or sells tobacco products to a minor and/or fails to demand proof of age will be guilty of a Class II misdemeanor.

Any minor who purchases, attempts to purchase or receives tobacco products and/or uses false proof of age to purchase tobacco products will be guilty of a Class II misdemeanor.

Illegal for minors to:

Purchase: Yes Possess: No Use: No

Excise Tax

North Carolina's tax rate is 5 cents per cigarette pack—the third lowest in the nation. The national average is 38 cents per pack.

Advertising

G.S. 14-313 prohibits any local county, city or town to enact regulations concerning the display or promotion of tobacco products.

State Preempts Local Laws

NC does not allow municipalities or counties to enact smoke-free air laws, minors' access laws, nor regulations regarding the display and promotion of tobacco products. NC is one of only a few states that preempts local control in all three areas. **This represents an enormous barrier for local communities because it greatly limits their ability to protect public health and safety.**

Table 1

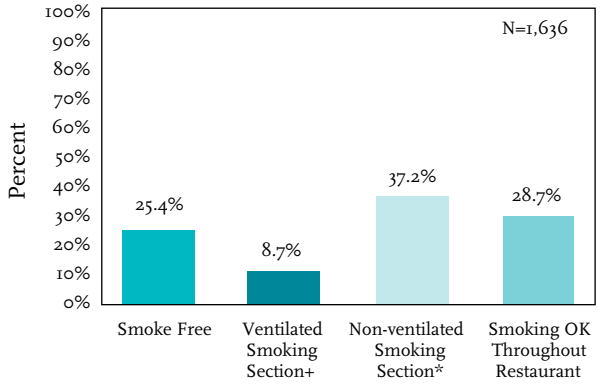
SITE	LEVEL OF RESTRICTIONS				PENALTIES	
	100% Smoke free	Designated smoking w/ separate ventilation	Designated smoking areas required or allowed	None	To businesses	To smokers
Government worksites			✔ Smoking areas are required: non-smoking areas allowed			
Private worksites				✔		
Restaurants				✔		
Day Care Centers				✔		
Home-based day care				✔		

[1] Centers for Disease Control and Prevention (CDC) State Tobacco Control "1999 Highlights"

Restaurants

A 1999-2000 survey of 1,636 North Carolina restaurants shows the following voluntary smoking policies.

FIGURE 5. PROVISIONS FOR SMOKING—NC HEART HEALTHY RESTAURANT (Survey 1999-2000)



\+ Smoking is permitted only in enclosed designated areas with exhaust ventilation.
* Smoking is permitted only in designated areas but tobacco smoke is not contained or removed with separate ventilation.
Source: Phil Bors, MPH, Division of Public Health, NC Department of Health and Human Services, Division of Public Health, 2000

Schools

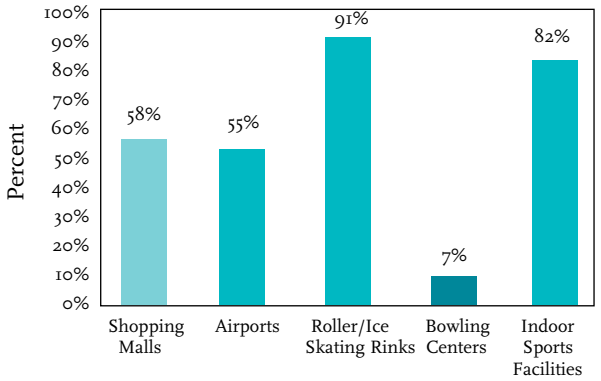
A 1999 survey of the 117 local school districts showed that only 6 school districts prohibit any tobacco use by students, staff, and visitors on school property during the school day and during school related events.

See Appendix IV for list of school districts where tobacco use is not allowed anytime, anywhere.

Family-Oriented and Recreational Facilities

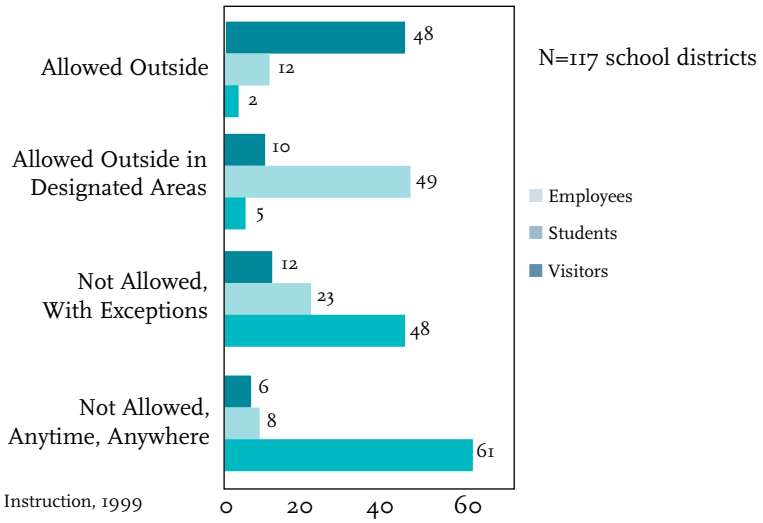
A 2000 survey of family-oriented and recreational facilities including shopping malls, airports, roller/ice skating rinks, bowling centers and indoors sports facilities showed the following voluntary smoke-free policies.*

FIGURE 6. PERCENT OF NORTH CAROLINA SMOKE-FREE ESTABLISHMENTS



* Source: Adam Goldstein, MD, Department of Family Medicine, School of Medicine, UNC-Chapel, 2000

FIGURE 7. NC SCHOOL DISTRICT SMOKING POLICIES



Source: NC Department of Health and Human Services/Department of Public Instruction, 1999

OVER THE PAST EIGHT YEARS, the public health movement to prevent tobacco use among young people, pregnant women and tobacco users who want to quit has been led by the NC Department of Health and Human Services, Tobacco Prevention and Control Branch (formerly Project ASSIST) within the NC Division of Public Health. Major partners are: NC Substance Abuse Services, the Health Action Council of NC (a collaboration between the American Cancer Society and the American Lung Association), NC Medical Society, a SmokeLess States Grant Initiative which funds the NC SAVE Program, NC Division of Alcohol Law Enforcement, NC Department of Public Instruction, NC Prevention Partners, American Heart Association, and the NC Division of Women's and Children's Health.

A conservative estimate based on the coalition membership indicates more than 1000 individuals and agencies participate in current programs. Each of these organizations agree that North Carolina is now ready to plan and implement a comprehensive tobacco use prevention program.

Our state, however, currently does not have enough funding for programs and policy interventions to have a sustained impact. Existing statewide programs receive approximately $3 million annually from federal and short-term private sources. By comparison, the CDC recommends $42.5 million as the minimum total annual funding for a comprehensive tobacco use prevention and control program in North Carolina, with $118.6 million as the upper estimate.

FIRST, to be successful, program interventions are needed at the community level. Strong home-grown models exist in the 10 community-based coalitions funded by Project ASSIST in 1993-1999. North Carolina's youth empowerment movement is gaining momentum from programs such as: Governor's Summit on Preventing Teen Tobacco Use, UJIMA, a youth-led, adult supported African American model program, SWAT (Students Warning Against Tobacco), TATU (Teens Against Tobacco Use), and from grants awarded to the State by the Robert Wood Johnson Foundation, Governor's Crime Commission, and the American Legacy Foundation.

WITH ADEQUATE AND SUSTAINED FUNDING, NORTH CAROLINA HAS A UNIQUE OPPORTUNITY TO MAKE A REAL DIFFERENCE REDUCING DEATH AND DISABILITY CAUSED BY TOBACCO USE.

SECOND, the policy and program efforts needed to enforce our youth access to tobacco law, to create local policies to make our schools 100% tobacco-free and to create policies to reduce exposure to environmental tobacco smoke are critical, and can build upon continued support from diverse partners across the state.

THIRD, states that have been successful at reducing tobacco use have utilized comprehensive mass media campaigns to inform the public about the dangers of tobacco use and secondhand smoke. Adequate funding provides the opportunity to build new relationships with North Carolina media, especially youth-oriented media outlets through the state, to create a wave of paid and public service placements of tobacco use prevention messages.

FOURTH, tobacco use prevention advocates nationwide have developed a solid base of prevention and cessation/treatment programs. There is great opportunity, with significant and sustained funding, to collaboratively build upon current programs to prevent and reduce tobacco use in our state.

WHILE YOUTH SMOKING rates have increased in North Carolina and many other states during recent years, a few states have developed strategies that have actually reduced tobacco use, consumption and prevalence. These well-funded, comprehensive programs serve as models for the nation. During the past decade, the CDC has extensively monitored public health programs nationwide that prevent and reduce tobacco use. Based on these scientific findings, the CDC provided the State of North Carolina with guidelines for expenditures necessary to establish an effective statewide tobacco use prevention program.

Through evidence-based analyses of successful population-based statewide programs and intense involvement with settlement states, CDC recommends that states establish comprehensive tobacco use prevention programs. These programs include an array of known-to-be-successful components that are sustained over time and utilize youth-focused community coalitions and partnerships.

The CDC, National Cancer Institute, Institute of Medicine, Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Prevention (CSAP), American Medical Association, American Cancer Society, and the American Lung Association agree that funding a multiple-strategies approach involving public education, policy, and programmatic efforts at the state and community level is essential to reduce and prevent tobacco use among teens and other priority populations. Effective population-based programs first began in California (from 1989), then Massachusetts (from 1993), Arizona (from 1994), and Oregon (from 1996). In addition, Florida began a comprehensive program in 1997, which was funded by a percentage of the state's tobacco settlement. (For a list of successes from these states see Appendix I.)

A common theme within these successful comprehensive programs is their "focus on changing smoking behavior at the population level through strategies which alter the social environment in which smoking and cessation occurs."[2] In the past few years, these five states have seen reductions in adult and/or teen tobacco use while, quite the contrary, the remainder of the nation has seen no declines in adult smoking and dramatic increases in teen tobacco use.

This framework incorporates a statewide program using multiple strategies and elements. The CDC's *Best Practices for Comprehensive Tobacco Control Programs* serves as a guide for North Carolina's comprehensive program. Ongoing evaluations of program activities will steer the course toward meeting the state's overall goals and objectives.

The Guiding Principles lay out the groundwork to work effectively with partners across the state.

[2] Wakefield, M &Chaloupka, F. (June 2000). *Effectiveness of comprehensive tobacco control programmes in reducing teenage smoking in the USA.* Tobacco Control. London: BMJ Publishing Group, June 2000, vol. 9, No.2

DEVELOPED IN COLLABORATION WITH NORTH CAROLINA PARTNERS
1999-2000

❏ **BUILD IT BASED ON THE EVIDENCE.** Establish a well-funded and sustained comprehensive, multicultural tobacco program that employs a variety of effective, evidence-based approaches, based upon critical elements in the Centers for Disease Control and Prevention's *Best Practices for Comprehensive Tobacco Control Programs*, with an emphasis on preventing teen tobacco use.

❏ **PLAN STRATEGICALLY.** Plan using strategic models such as ACT-ON: analyze Advantages (Strengths), Challenges, Threats, Opportunities, and Next Steps. Be prepared for changing direction in a rapidly changing environment.

❏ **EDUCATE, INSPIRE AND CELEBRATE SUCCESS!** Positive approaches often lead to greater, longer lasting change. And folks like to be a part of a winning team!

❏ **STRENGTHEN EXISTING INTERVENTIONS.** Build upon and expand the current infrastructure and critical partnerships at the local and state levels to plan and carry out comprehensive tobacco prevention and control programs.

❏ **ENGAGE YOUTH AND OTHER AT-RISK GROUPS AS LEADERS.** To reduce tobacco use, work within at-risk or under-served populations. Promote diverse leadership in planning and implementing policy and programmatic efforts.

❏ **CHANGE THE BROADER SOCIAL NORMS.** Tobacco use does not occur in a vacuum. A comprehensive program effort must change social norms surrounding tobacco use, using media, policy and culturally competent community organizing as tools.

❏ **FOCUS WHERE NEED IS GREATEST.** Develop strategies to eliminate disparities among racial, ethnic and low-income populations.

❏ **CAPITALIZE ON DIVERSE STRENGTHS AND ASSETS OF PARTNERS.** Ensure state-level and community support through partnerships with youth and adult stakeholders, experts, and organizations in North Carolina with specialized expertise to develop surveillance plans and to deliver and evaluate effective strategies.

❏ **ENHANCE CAPACITY.** Utilize the strengths of state and local partners to build capacity statewide for tobacco use prevention and control in health care settings, schools, and community groups. Increase understanding of the problem among policymakers and the news media.

❏ **KEEP IT LOCAL AND LOUD.** Ensure that policies and programmatic activities are feasible and acceptable at the local level. Then promote them with youth and other leaders as spokespersons.

❏ **PROMOTE ACCOUNTABILITY.** Incorporate a strong surveillance and evaluation component from the program's inception to ensure accountability and effectiveness.

OVERALL STATEWIDE OUTCOMES

Healthy Carolinians 2010

1. By 2010, decrease overall teen tobacco use from 38.3% to 19.1%.
2. By 2010, decrease the proportion of adults who smoke from 25% to 12%.
3. By 2010, reduce the proportion of pregnant women who smoke from 15.2% to 10%.

OVERALL STATEWIDE PROGRAM GOALS

1. Prevent initiation and promote quitting of tobacco use among youth.
2. Eliminate exposure to environmental ("secondhand") tobacco smoke.
3. Promote quitting of tobacco use among adults.
4. Eliminate disparities by improving the health-related norms of vulnerable and underserved racial, ethnic, and income groups more adversely affected by tobacco use.

2010 PROGRAM OBJECTIVES

(for each goal)

GOAL 1: PREVENT INITIATION AND PROMOTE QUITTING AMONG YOUTH

OBJECTIVES

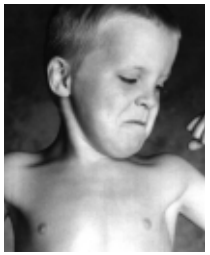
1. Increase from 29.8% to 60% the proportion of young people in high school who have never smoked. (*YTS 1999*)

2a. Decrease the proportion of middle school students who use tobacco products from 18.4% to 9.2% and high school students who use tobacco products from 38.3% to 19.1%. (*YTS 1999*)

2b. Decrease the proportion of middle school student who smoke from 15% to 7.5% and high school students who smoke from 31.6% to 15.8% (*YTS 1999*).

3. Increase from 5.1% to 100% the proportion of school districts in North Carolina that are 100% tobacco free for students, staff and visitors in school buildings, the campus, and in school-related events (*DPI/DHHS survey 1999*)

4. Reduce the rate of illegal sales of tobacco products to minors at retail stores and vending machines from 20% to 5%. (*DHHS, Substance Abuse Services Section 2000 Annual Synar Survey*)



STRATEGIES

A. Empower youth as tobacco prevention and control advocates.

B. Empower youth as peer counselors for cessation.

C. Deglamourize tobacco use and increase public awareness through paid advertising, public service placements and public relations.

D. Earn pro-health media coverage.

E. Provide media literacy education and training.

F. Promote effective tobacco use prevention and control policies in schools and communities.

G. Assure a comprehensive approach to tobacco use prevention and control in all schools grades K-12.

H. Promote and provide access to cessation services to all youth and adults.

I. Increase merchants' understanding of and commitment to reducing youth access to tobacco products through the delivery of an effective statewide merchant education program.

J. Increase compliance with the State's Youth Access Law through the development and implementation of a sustained statewide enforcement and awareness program.

2010 PROGRAM OBJECTIVES

GOAL 2: ELIMINATE EXPOSURE TO ENVIRONMENTAL TOBACCO SMOKE

OBJECTIVES

1. Increase from 5.1% to 100% the proportion of schools districts in North Carolina that are 100% tobacco free for students, staff and visitors in school buildings, the campus, vehicles, and in school events (*DPI/DHHS survey 1999*).
2. Increase from 60.7% to 100% the proportion of North Carolina workers covered by a formal smoking policy that prohibits smoking entirely or limits it to separately ventilated non-essential portions of the workplace (*CPS 1999*).

2a. Increase smoke-free policies in the following public indoor recreation sites in North Carolina (UNC Dept. of Family Medicine, 1999):
- ❏ Indoor malls from baseline of 58% to 100%.
- ❏ Commercial airports from baseline of 55% to 100%.
- ❏ Roller/iceskating rinks from baseline of 91% to 100%.
- ❏ Bowling centers from baseline of 7% to 100%.
- ❏ Indoor spectator facilities from baseline of 82% to 100%.

3. Increase the percentage of North Carolinians reporting smoke-free homes from 52.2% (*1998/99 CPS data*) to 74%.
4. a: Decrease from 48.8% to 24.4% the percentage of middle school students reporting living with someone who smokes (*YTS 1999*).
   b: Decrease from 46.0% to 23% the percentage of high school students reporting living with someone who smokes (*YTS 1999*).

STRATEGIES

A. Promote adoption of nonsmoking policies in:
- ❏ Homes
- ❏ Daycare Facilities
- ❏ Schools
- ❏ Restaurants
- ❏ Family-Oriented businesses, e.g. shopping malls, recreational facilities, bowling alleys, hair salons/barbershops, sports arenas, etc.
- ❏ Workplaces
- ❏ Public Places

B. Earn pro-health media coverage.
C. Develop and run paid media on the health risks of tobacco use.
D. Promote nonsmoking establishments through the web, paid media, and earned media.
E. Raise public awareness of the risks of secondhand smoke related to asthma.
F. Provide in-home inspections and quit services for families of asthmatics.
G. Raise public awareness in underserved racial, ethnic and income groups more adversely affected by secondhand smoke.

[3] Fiore MC, Bailey WC, Cohen SJ, et al (June 2000) Treating Tobacco Use and Dependence. *Clinical Practice Guideline*. Rockville, MD: US Dept. of Health and Human Services.

GOAL 3: PROMOTE QUITTING AMONG ADULTS

OBJECTIVES

1. Decrease proportion of adults who smoke from 25% to 12% (*BRFSS, 1999*).
2. Decrease the proportion of young adults, ages 18-24, who use spit tobacco from 5.0% to 3.75%. (*BRFSS*).
3. Decrease proportion of pregnant women who smoke from 15.2% to 10% (*SCHS Vital Statistics/Birth Certificate data, 1998*)
4. Increase from 8% to 100% the public and private health plans in NC that include the clinical practice guidelines for treating tobacco use and dependence as a covered benefit in their most basic benefits package (*NC Prevention Partners, 2000*).

STRATEGIES

A. Promote and provide access to effective cessation/treatment services for all adults and youth who want to quit by developing a multi-level NC Quitting Infrastructure.
B. Develop state-level position with oversight authority/accountability for cessation services and programs.
C. Continue to support voluntary insurance reform initiative and partnerships with NC public and private health plans to expand coverage of comprehensive smoking cessation/treatment benefits (behavioral and pharmacological).
D. Increase level of employer and public purchasers requesting and paying for cessation/treatment benefits.
E. Increase the proportion of, and maintain updated resource directory of health care facilities (hospitals, health departments, medical care practices) in NC with quitting programs that follow the Clinical Practice Guidelines for smoking cessation.
F. Develop and provide training and technical assistance to health professionals and health professional students on evidence-based guidelines, develop and promote programs for special populations, and develop and promote tools to treat tobacco use as a vital sign.
G. Provide direction for medical/dental offices to make systems changes to properly emphasize smoking cessation/treatment for their patients.
H. Establish and promote a NC culturally and linguistically appropriate 24 hour NC Quit-line and on-line quitting programs.
I. Develop and promote consumer utilization of quitting programs through NC tailored public awareness quitting campaigns.
J. Establish financial incentives for health agencies to develop quitting infrastructure through partnerships with NC foundations and other funding resources.
K. Establish evaluation program that measures effectiveness of cessation/treatment strategies and progress towards quitting goals.

GOAL 4: ELIMINATE DISPARITIES BY IMPROVING THE HEALTH RELATED NORMS OF POPULATIONS MORE ADVERSELY AFFECTED BY TOBACCO USE

OBJECTIVES

1. Decrease tobacco use among all NC middle school students to 9.2% from the current rates of: African American students (19.8%), Hispanic students (20.5%), White students (16.8%), rural middle school students (20.2%), and urban middle school students (15.9%) (*NC YTS, 1999*).
2. Decrease tobacco use among all NC high school youth to 19.1% from the current rates of: White students (42.5%), Hispanic students (33.9%), African American students (28.7%), rural students (41.2%) and urban students (35.2%) (*NC YTS, 1999*).
3. Decrease cigarette smoking among all NC adults to 12%.
    a) Current rates for ethnic groups are: NC White adults (25.2%), NC African American adults (24.6%), NC Hispanic adults (22.7%) and other minorities (23.3%), which include Native Americans and Asians.
    b) Current rates for education levels are: adults with less than a high school diploma (34%), adults with some college education (18%). (*NC BRFSS, 1999*).
    c) Current rates for gender are: adult males who smoke (27.5%), female adults who smoke (22.7%) (*BRFSS, 1999*).
4. Decrease the proportion of all pregnant women who smoke from an average of 15.2% to 10% (16.8% of white women; 11.2% of African American women and 11.4% of other minorities). Maintain the low rate of Hispanic women who smoke during pregnancy (2.1%) (*NC Vital Statistics, 1998*).

STRATEGIES

Incorporate diversity in all four goal areas

GOAL 1: Prevent initiation and promote quitting among youth

A. Increase the number of diverse youth leaders, community groups and organizations representing underserved populations actively involved in tobacco prevention and control.
B. Increase the number of schools with large proportion of minority populations that adopt 100% tobacco-free policy.
C. Train diverse youth as peer counselors for cessation.
D. Develop culturally appropriate youth leadership models such as the "UJIMA" model for African American youth. Promote African American youth leadership using the "UJIMA" model across the state.
E. Work with immigrant, diverse and underserved populations to reduce the socialization of tobacco use as a norm among youth. Organizations such as El Pueblo and the NC Commission of Indian Affairs will be engaged.

GOAL 2: Eliminate exposure to environmental tobacco smoke

F. Incorporate role modeling into educational strategies. Emphasize the influence of parents, educators and adult youth leaders on youth initiation to tobacco use, especially in ethnic communities.

GOAL 3: Promote quitting of tobacco use among adults

G. Develop effective cessation services for people with low socio-economic status such as workplace and health care programs.
H. Develop and promote culturally appropriate cessation models, such as *Pathways to Freedom*.

GOAL 4: Eliminate disparities by improving the health-related norms of populations more adversely affected by tobacco use

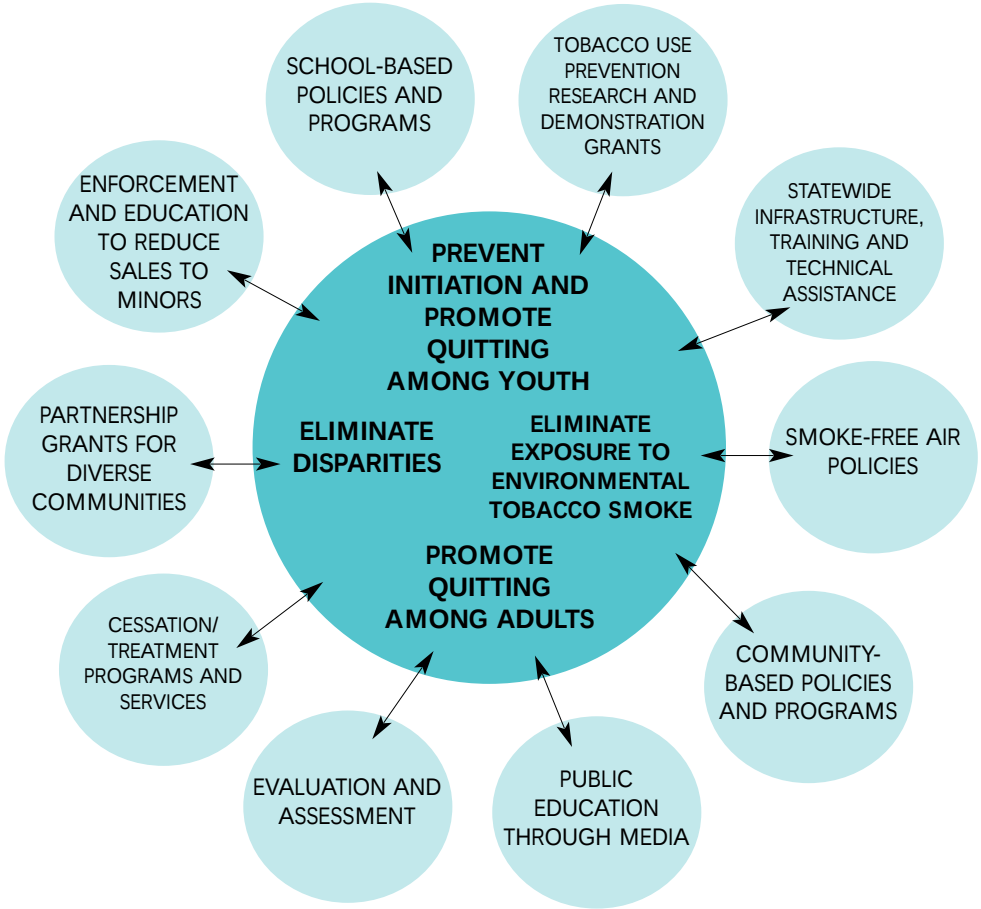
I. Promote tobacco prevention and control efforts through culturally appropriate paid advertising and public relations. Increase the proportion of pro-health media coverage in media aimed at specific populations.
J. Obtain tobacco prevalence data reflecting a more accurate representation of diverse ethnic and cultural groups such as Native Americans, Hispanic/Latinos and Asian Americans.
K. Address cultural tobacco use among Native Americans by education on the difference between ceremonial use and addictive use of manufactured tobacco. Raise public awareness to processing and manufacturing of tobacco (chemical additives) especially among Native American communities.

THE TEN ELEMENTS DESCRIBED BELOW create a comprehensive tobacco use prevention plan to achieve the outcomes, goals and objectives described earlier in this document. These elements are not intended to represent a menu from which to select activities that seem more *doable* in North Carolina. Each element is related to the others, and all are necessary for building an effective plan to reduce the toll of death and disease brought on by tobacco use in North Carolina. The elements are:

1. Enhancing community-based policies and programs for tobacco use prevention
2. Enhancing school-based polices and programs in tobacco use prevention
3. Strengthening policies, enforcement and education to reduce tobacco sales to minors
4. Promoting smoke-free air laws/policies
5. Distributing grants to reach diverse communities and underserved populations
6. Supporting grants for tobacco use prevention research and demonstration projects
7. Increasing public education through media
8. Promoting effective tobacco cessation/treatment policies, programs and services
9. Establishing statewide infrastructure and management for all state and local programs
10. Enhancing evaluation and assessment of all tobacco use prevention programs

FIGURE 8. represents the ten elements of a comprehensive plan needed to achieve the four statewide goals. Each element listed in the outer circle works synergistically to achieve the goals listed in the inner circle. The goals are within reach. It's time to move ahead and achieve them.

FIGURE 8. COMPREHENSIVE TOBACCO USE PREVENTION VISION PLAN



I. ENHANCING COMMUNITY-BASED POLICIES AND PROGRAMS FOR TOBACCO USE PREVENTION

COMMUNITIES BEAR THE BURDEN for tobacco use. Relatives, neighbors, businesses, and communities share the loss of loved ones due to heart disease, cancer and emphysema, and community services struggle to pay the costs for treatment. In addition, individuals use tobacco in the context of their communities. They make choices to try tobacco, use it and maintain their nicotine addictions based, at least in part, on the way their communities view tobacco use and make provisions for it.

According to the Centers for Disease Control, community-based programs must focus on all four goals:

1) **Preventing initiation and promoting quitting among youth;**
2) **Eliminating exposure to environmental ("secondhand") tobacco smoke;**
3) **Promoting quitting among adults, and;**
4) **Eliminating disparities by improving the health related norms of groups more adversely affected by tobacco use.**

Evidence from tobacco control programs in California, Massachusetts, Arizona, Oregon and Florida indicate that the most successful approaches to reducing tobacco use and exposure to environmental tobacco smoke feature a multi-faceted, community-based strategy.

The NC ASSIST program (1991-99) invested 90% of its intervention dollars into community-based programs aimed at changing social norms and public and private policies on tobacco use. Resources were allocated based on population, keeping in mind that successful programs need paid staff to run them. Currently, the NC Tobacco Prevention and Control Branch provides limited funds and technical assistance to 10 community-based coalitions. This has been a successful model, where programs are coordinated at the state level and implemented at the local level. These coalitions are considered leaders in tobacco use prevention and control.

Adequately funded, effective local tobacco use prevention programs are needed in all 100 counties of North Carolina. The success of local ASSIST models has raised the interest and enthusiasm of many non-ASSIST counties that now stand ready to begin tobacco control programs.

In a recent statewide survey of local health directors conducted by the NC TPCB, 70 health directors replied that they would be ready between now and 2004 to begin tobacco use prevention and control programs in their counties.

To achieve lasting changes, programs in local government require funds to hire staff, provide operating expenses, purchase educational materials and resources, conduct education and training programs, support communication campaigns and recruit as well as maintain local partnerships. Core funding will be allocated to local government units or community organizations using a formula that takes into consideration population and past activities, as well as need for staff to implement programs and support local coalitions and partnerships. NC TPCB will ensure that diverse populations receive training and support within their local communities.

Local coalitions could include, but should not be limited to: **health departments, area mental health and substance abuse programs, voluntary agencies, schools, youth groups, universities, hospitals, local medical societies and other health care facilities, worksites, community groups, sports and recreation facilities and faith communities.** Coalitions will build community support for and promote effective public health policies that encourage tobacco-free norms. Such policies can focus on smoke-free air, economic disincentives to use tobacco, youth access and advertising restrictions, and promoting quitting through insurance coverage for evidence-based cessation/treatment activities.

II. ENHANCING SCHOOL-BASED POLICIES AND PROGRAMS IN TOBACCO USE PREVENTION

SCHOOL-BASED PROGRAMS that identify the social influences which promote tobacco use among youth and teach skills to resist such influences are effective ways to prevent tobacco use and encourage cessation (*Surgeon General's Report, 1994*). The Centers For Disease Control has developed *Guidelines for School Health Programs to Prevent Tobacco Use and Addiction* to achieve national health and education goals.

Based on the national CDC guidelines, the NC Tobacco Prevention and Control Branch (TPCB) has worked with the Department of Public Instruction—NC Safe and Drug-Free Schools Program, Healthful Living Curriculum and the Healthy Schools Initiative, along with the American Lung Association of NC, to implement the Tobacco Free Schools Model training program. The guidelines and training programs recognize that school initiatives will be most effective in preventing tobacco use and addiction if they:

- Develop and enforce a tobacco-free schools policy for students, staff and visitors in school buildings, school grounds, school vehicles and school-related events
- Promote youth-led, adult-supported, school-wide activities for tobacco use prevention
- Provide an alternative-to-suspension program—help students who violate the smoking policy to quit smoking rather than just punishing them through suspension
- Provide tobacco use prevention education in grades K-12
- Offer training for school personnel regarding policy, programs and curricula
- Coordinate initiatives with programs focusing on school nutrition, physical activity, health education, and school environment
- Involve parents and families in support of school-based programs and cessation efforts
- Provide science-based cessation services for students and staff
- Link school-based programs with local community coalitions
- Assess the tobacco use prevention program at regular intervals

Governor Michael F. Easley and Mike Ward, State Superintendent of Public Instruction, are encouraging all local school leaders to implement 100 percent tobacco-free policies in their schools. The *Grassroots Guide to Tobacco-Free Schools* has been published and sent to all middle and high schools in North Carolina by the TPCB. A new teen-focused website—*www.StepUpNC.com*—encourages teens to advocate for tobacco-free school policies and programs. The Branch also works in partnership with the Department of Public Instruction to promote a comprehensive Tobacco-Free Schools model, providing training and tools for school faculty and students, as part of a coordinated school health program.

Complimentary to the school training programs is *Teens Against Tobacco Use*, implemented by the American Lung Association of NC and the American Cancer Society, Southeast Division. This program helps create youth advocates for preventing teen tobacco use. As this project strives to reach more children and adolescents, the need for broad-scale youth involvement and leadership grows stronger.

A student group known as SWAT (Students Warning Against Tobacco) at Independence High School in Charlotte serves as an excellent model for student advocacy and involvement in teen tobacco use prevention. Other models exist as well.

The American Lung Association's Not-On-Tobacco (N-O-T) teen cessation program is science-based and can be effectively implemented in the schools. Currently, the TPCB is funding the American Lung Association to conduct N-O-T facilitator training programs. Also Substance Abuse Services and the Area Mental Health/Developmental Disabilities/Substance Abuse Services currently provide funds to the American Lung Association to train local Substance Abuse professionals in the N-O-T program and to provide Substance Abuse prevention programs in the schools.

NC Survivors and Victims Empowered (of Tobacco) or SAVE works with schools to bring survivors' messages to a widening audience of young people. Survivors tell their stories effectively in school-wide assemblies and in classrooms, and bring powerful testimony for tobacco-free policies.

ACTIVE ENFORCEMENT, COMBINED WITH EDUCATION, IS THE ONLY STRATEGY PROVEN TO REDUCE YOUTH ACCESS TO TOBACCO PRODUCTS.

III. STRENGTHENING POLICIES, ENFORCEMENT AND EDUCATION TO REDUCE TOBACCO SALES TO MINORS

SECTION 1926 of the Public Health Service Act, commonly referred to as the Synar Amendment, is administered through the Substance Abuse Prevention and Treatment (SAPT) Block Grant and requires states to conduct specific activities to reduce youth access to tobacco products. One of these activities is to "enforce the youth access law in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under the age of 18." Failure to comply with the requirements of the federal Synar Amendment could result in a 40 percent non-compliance penalty amounting to more than a $13 million reduction in North Carolina's SAPT Block Grant.

During the 1997 legislative session of the General Assembly, Senate Bill 143 entitled *Stop Tobacco Sales to Minors* was ratified. This legislation became effective December 1, 1997 and strengthened the law by providing for the following:

- Removing the word "knowingly" from sales and distribution language of the law;
- Requiring photo ID checks for anyone under age 18 years of age;
- Requiring store managers to post signs regarding the law on tobacco sales to minors; and
- Prohibiting vending machine sales, except in adult-only establishments or in establishments that provide continuous control in order to activate the machine prior to purchase.

In that same year, former Governor Jim Hunt signed Executive Order 123 designating the NC Division of Alcohol Law Enforcement (ALE) as the lead agency to implement model merchant education and enforcement of the State's youth access law. Since that time, the combined enforcement and educational efforts have resulted in a reduction of the rate at which minors can purchase tobacco products from 45% in 1997 to 20% in 2000.

In 1999, ALE's federal FDA contract that funded enforcement activities was eliminated due to the US Supreme Court decision regarding FDA authority to regulate nicotine, sales and promotion of tobacco products to minors. Currently the Substance Abuse Services Section is providing a limited, one-year only, budget transfer to ALE to cover tobacco enforcement and education during fiscal year 2000-2001.

Active enforcement, combined with education, is the only strategy proven to reduce youth access to tobacco products. Current gaps in manpower and funding for active statewide enforcement threaten the State's ability to continue to comply with the Synar Amendment. Resources are needed to sustain a statewide enforcement and merchant education program. One model merchant education program is conducted by "UJIMA"—African American Youth Leadership Initiative.

FOR MEANINGFUL CHANGE TO OCCUR IN ELIMINATING ENVIRONMENTAL TOBACCO SMOKE, STATE AND LOCAL COMMUNITY LEADERSHIP AND INVOLVEMENT ARE NEEDED.

IV. PROMOTING SMOKE-FREE AIR LAWS/POLICIES

SECONDHAND SMOKE is a known human lung carcinogen and a serious health threat to children. Secondhand smoke both causes and exacerbates asthma, the leading cause of school absenteeism due to a chronic illness in the state. Almost half of NC middle school students (48.8%) and high school students (46.0%) live with someone who smokes.

North Carolina law G.S. 143-595 *(Smoking in Public Places)* requires that 20% of state controlled buildings be set aside for smoking and preempts local governments from passing anything stricter since October, 1993. Despite this preemptive "dirty air law," North Carolina showed a 77% increase in workers covered by nonsmoking policies, as organizations have passed voluntary private policies in response to increased understanding of secondhand smoke as a serious health threat and a growing demand from employees and customers. Schools are exempt from the state law, and Governor's Office and Department of Public Instruction have promoted 100% tobacco-free schools among local school leaders. The community coalitions funded through the Tobacco Prevention and Control Branch have promoted voluntary clean indoor policies in restaurants, work-sites, and family oriented businesses.

For meaningful change to occur in eliminating environmental tobacco smoke, state and local community leadership and involvement is needed. Rallying the support of individuals most affected by secondhand smoke is critical to the success of this effort. Core funding is needed for state and local collaborative activities to promote adoption of nonsmoking policies in:

- Homes
- Daycare Facilities
- Schools
- Workplaces
- Restaurants
- Family oriented businesses, e.g. shopping malls, recreational facilities, bowling alleys, hair salons/barbershops, sports arenas, etc.
- Public Places

V. DISTRIBUTING GRANTS TO REACH DIVERSE COMMUNITIES AND UNDERSERVED POPULATIONS

"SOCIAL POSITION, ECONOMIC STATUS, CULTURE, AND ENVIRONMENT ARE CRITICAL DETERMINANTS OF WHO IS BORN HEALTHY, WHO GROWS UP HEALTHY, WHO SUSTAINS HEALTH THROUGHOUT THEIR LIFE SPAN, WHO SURVIVES DISEASE, AND WHO MAINTAINS A GOOD QUALITY OF LIFE AFTER DIAGNOSIS AND TREATMENT. ...THE UNEQUAL BURDEN OF DISEASE IN OUR SOCIETY IS A CHALLENGE TO SCIENCE AND A MORAL AND ETHICAL DILEMMA FOR OUR NATION."[1]

HEALTHY PEOPLE 2010, CDC, American Legacy Foundation and The Robert Wood Johnson Foundation have all identified elimination of health disparities among the different segments of the population as a priority. National data clearly show that population groups such as African Americans, Hispanic/Latinos, Native Americans, and Asian/Pacific Islanders and people with less than high school education and those living below the poverty level are at high risk for tobacco related health problems. For example, the 1998 Surgeon General's Report shows "nearly 40% American Indian & Alaskan Native adults smoke cigarettes, compared to 25% of overall U.S. population"[2]. Also, each year, "approximately 45,000 African Americans die from a preventable smoking-related disease". U.S. studies show that African American teens are at a greater risk of tobacco addiction and Asian American smoking rates jump after elementary school. More data is needed for other population groups such as Gay/Lesbian/Bisexual/Transgender. For example, one report shows gay men have a 47% smoking rate as compared to a 29% rate among men in general adult male population[3].

In North Carolina, minority and low-income populations show high levels of tobacco use prevalence and the related health problems. Furthermore, NC data is needed to clearly show the tobacco prevalence rates among "Other Minorities" such as Native Americans and Asian Americans. In some surveys the only data available for North Carolina is for White, African American, and Hispanic populations.

This comprehensive plan works toward addressing those health disparities in North Carolina caused by tobacco use. Statewide and local partnership grants are a vital element to an effective tobacco use prevention plan by broadening the base of support within the state for tobacco use prevention efforts. The grants would focus primarily on building the capacity of state and local organizations and networks that reach diverse communities, and underserved populations. In order to be successful the grants must provide funding to:

- ensure the development of culturally and linguistically appropriate prevention and cessation programs;
- build capacity;
- provide technical assistance and training;
- develop culturally relevant media campaigns;
- increase the representation of diverse community leaders on key advisory boards, task forces, and strategic planning communities that results in substantive tobacco control improvements.

In order for these initiatives to be effective, community leaders must have input into how the health disparities resulting from tobacco use are addressed. Therefore, this plan includes leaders from diverse populations in the planning, implementation, and evaluation of the statewide and local partnership grants programs. In that way, the Request for Application (RFA) process will more accurately reflect the needs of the various communities across the state.

The State can empower diverse communities to help eliminate disparities in tobacco use among North Carolina's various populations. For example, the African American Action Team has developed and implemented an adult-supported, youth-led model, "UJIMA". As a result, many African American youth build their leadership skills while working in their community and across the state to prevent tobacco use. New initiatives are underway with American Indians and Hispanic youth and their communities. These represent the first steps in the path toward addressing tobacco-related health disparities.

[1] National Cancer Institute (2000). Plans and Priorities for Cancer Research. Website: http://plan2002.cancer.gov/
[2] US DHHS (1998) Tobacco Use Among U.S. Racial/Ethnic Minority Groups.
[3] Stall, R.D., et al. (1999). Cigarette Smoking Among Gay and Bisexual Men. American Journal of Public Health. December 1999, vol. 89, No. 12, pp. 1875-1878

VI. SUPPORTING GRANTS FOR RESEARCH AND DEMONSTRATION PROJECTS

COMPETITIVE GRANTS WILL OPEN OPPORTUNITIES FOR EFFECTIVELY ADDRESSING THE CHANGING POLICY AND SOCIAL NORMS WITHIN THE STATE TO PREVENT YOUTH INITIATION OF TOBACCO USE; TO PROMOTE QUITTING AMONG YOUNG PEOPLE AND ADULTS; TO ELIMINATE EXPOSURE TO ENVIRONMENTAL TOBACCO SMOKE ...

INNOVATIVE NORTH CAROLINA-SPECIFIC and investigator-initiated projects for tobacco use prevention research and demonstration are critical for improving tobacco use prevention and control programs. Although national funding agencies, such as the National Cancer Institute and the Centers for Disease Control and Prevention, fund research for tobacco control, they have not funded many projects that have directly involved developing tobacco use prevention in tobacco growing states like North Carolina. Therefore, these research and demonstration projects should focus on areas relevant for improving tobacco use prevention efforts in North Carolina. Competitive grants will open opportunities for effectively addressing the changing policy and social norms within the state to prevent youth initiation; to promote cessation among young people and adults; to eliminate exposure to environmental tobacco smoke and identify and eliminate the disparities related to tobacco use and its effects among vulnerable and underserved population groups. The tobacco use prevention and control research projects will increase the effectiveness of community programs by stimulating local efforts. An example is partnering with academia dedicated to promoting health in diverse communities through Historically Black Colleges and Universities. Local involvement in research projects that reflect the needs of the community will exhibit greater success.

The list below includes example investigator-initiated tobacco use prevention research projects on applied topics that are directly relevant to improving the tobacco use prevention and control program planning and the public's health.

These examples do not preclude other relevant studies. Example studies are:

1. Measuring environmental tobacco smoke (ETS) exposure levels in NC's public places
2. Creating a statewide tobacco control research center; interdisciplinary, state and local
3. Identifying and measuring the most effective media and communication strategies
4. Creating projects to identify gaps in addressing high risk populations, ethnic minority groups, rural residents, pregnant women and other underserved populations
5. Understanding innovative marketing for cessation among diverse tobacco users
6. Conducting qualitative research on effective cessation strategies for teens from diverse backgrounds (cultural/lifestyle, themes)
7. Developing and fostering cost-effective dissemination of efficacious cessation strategies that can reach underserved populations
8. Creating training programs that support research and training opportunities among graduate students and faculty from diverse racial and ethnic groups

VII. INCREASING PUBLIC EDUCATION THROUGH MEDIA

HISTORICAL EVIDENCE shows that well-coordinated public education campaigns that were aimed at a ratio of one anti-smoking ad for every four tobacco ads conducted by the American Cancer Society and American Lung Associations (enabled by the Fairness Doctrine when tobacco ads were still on television) reduced tobacco use nationwide.

Recent experiences from other states demonstrate that strong tobacco use prevention messages directed at youth, and sustained through public education initiatives increase youths' awareness of the dangers of tobacco use, prevent youth from starting, and encourage underage tobacco users to quit. Florida campaigns were highly visible, making the youth brand called *Truth* ubiquitous. A recent Florida statewide survey shows that, within the past two years, smoking declined by 54 percent among middle school students and by 24 percent among high school students. That translates to roughly 80,000 Florida students who are not smoking today.

Public education can also be a powerful influence on public support for tobacco use prevention policy changes and enforcement efforts, thus creating a supportive climate for school and community change. It is critical that there is coordination and support between public education local programs.

North Carolina has not had funding to plan and conduct a comprehensive public education campaign. However, through media advocacy work, or "earned media," media-tracking data show that since 1993 pro-health newspaper articles, editorials and letters to the editor in daily papers have increased from 20% to 70% of tobacco coverage. Pro-tobacco news coverage has decreased from 22% of tobacco coverage in 1993 to 5% in 1997. This type of work with news media will continue, with statewide coordination of training and technical assistance in media advocacy, editorial board advocacy and spokesperson preparation.

The NC Tobacco Prevention and Control Branch has had some success using paid media for limited campaigns. For example, in 1997 the branch worked on building support for tobacco control by reaching politically active citizens through placing day sponsorships on 11 public radio stations around the state. In December 2000, the Branch began drawing youth interested in tobacco prevention advocacy through a targeted radio campaign and teen website.

A public education program consists of printed materials, public relations, news media relations, web communications, as well as radio, television, billboard, and print advertising. Care must be taken to ensure that materials are developed and presented for the general market and diverse populations. All messages must be culturally appropriate. Special efforts should be made to represent NC's diverse populations. The effects of tobacco use on these populations should be emphasized by members of the affected groups.Focus group testing must be used to ensure effective message development. The public relations arm is critical in assisting efforts by local programs and supporting linkages and coordination between local program activities and the statewide campaign, as well as publicizing program results.

PUBLIC EDUCATION CAN ALSO BE A POWERFUL INFLUENCE ON PUBLIC SUPPORT FOR TOBACCO USE PREVENTION POLICY CHANGES AND ENFORCEMENT EFFORTS, THUS CREATING A SUPPORTIVE CLIMATE FOR SCHOOL AND COMMUNITY CHANGE. IT IS CRITICAL THAT THERE IS COORDINATION AND SUPPORT BETWEEN PUBLIC EDUCATION AND LOCAL PROGRAMS.

VIII. PROMOTING EFFECTIVE TOBACCO CESSATION/TREATMENT POLICIES, PROGRAMS AND SERVICES

NORTH CAROLINA'S QUITTING infrastructure is inadequate. However, recent progress in health insurance coverage is a critical foundation which can be built upon. Public and private purchasers in North Carolina must be encouraged to purchase cessation/treatment benefits from their health insurer. North Carolina medical care systems, including hospitals and substance abuse treatment programs, are moving towards but have not fully invested in tobacco use cessation/treatment programs for their patients/clients.

Accessible evidence-based cessation/treatment programs must be developed across all NC communities within schools, hospitals, health departments, private practices, substance abuse/mental health centers, worksites, and other settings and must be culturally competent for NC populations. North Carolina must add to its award-winning program, *Counseling Women Who Smoke* designed for medical providers to help pregnant women, *Pathways to Freedom* for African American populations, and the Not-On-Tobacco (NOT) program for teens, including an expansion of services tailored for Hispanic/Latino and Native American populations.

Smoking status must begin to be treated as a vital sign in all health care settings and tools are needed to help providers and health systems do so. Training programs tailored for physicians, dentists, substance abuse treatment professionals, nurses, health educators, medical practice office staff, school nurses, and others are needed for the delivery of effective counseling and treatment options for their patients/clients who use tobacco products. The NC Medical Society has an up-to-date program which has been in limited use. System changes are needed in both medical and dental offices to optimize tobacco use treatments. A statewide toll-free quit-line and on-line quitting program and resource guide must be available to provide tailored stop-smoking counseling services or referral to one. A high quality public awareness campaign to activate consumers to quit and to seek a local program is key to promoting utilization of the quitting infrastructure. Resources and evaluation partners must be sought with NC foundations and academicians to further develop and evaluate progress of cessation/treatment infrastructure in NC. Local community centers and churches members should be trained to offer effective cessation services to their communities.

ACCESSIBLE EVIDENCE-BASED CESSATION PROGRAMS MUST BE DEVELOPED ACROSS ALL NC COMMUNITIES WITHIN SCHOOLS, HOSPITALS, HEALTH DEPARTMENTS, SUBSTANCE ABUSE/MENTAL HEALTH CENTERS, WORKSITES, AND OTHER SETTINGS AND MUST BE CULTURALLY COMPETENT FOR NC POPULATIONS.

IX. ESTABLISHING STATEWIDE INFRASTRUCTURE AND MANAGEMENT FOR ALL STATE AND LOCAL PROGRAMS

IMPLEMENTATION OF an effective tobacco use prevention program requires a strong structure to provide management, statewide training and technical assistance. A statewide infrastructure must have the ability to administer, oversee and assist local programs and grant recipients in the community.

Recommendations should be based on the experience gained from working with other states that have successful tobacco use prevention and control programs. Adequate training should be offered to local programs and grant recipients on topics such as building strong coalitions/partnerships, media relations, advocacy and spokesperson skills, leadership, policy advocacy, diversity, reducing disparities, community organizing, merchant education, teacher training, cessation programs, public education campaigns, and local evaluation. State, regional and local staff should collaborate with work groups throughout the state to participate in planning and implementation of such training programs. Furthermore, the staff and coalitions should be representative of the populations they serve.

As a general planning guide, CDC recommends that training and technical assistance funds be divided into thirds. One-third of the training and technical assistance budget can be used for community and school programs, one-third can be used for public education programs, and one-third can be used for statewide programs, surveillance and evaluation, enforcement, and cessation.

STATE, REGIONAL AND LOCAL STAFF SHOULD COLLABORATE WITH WORK GROUPS THROUGHOUT THE STATE TO PARTICIPATE IN PLANNING AND IMPLEMENTATION OF SUCH TRAINING PROGRAMS.

X. ENHANCING EVALUATION AND ASSESSMENT OF ALL TOBACCO USE PREVENTION PROGRAMS

SURVEILLANCE IS NEEDED to continuously monitor measures such as tobacco-related behavior and attitudes, and is needed to evaluate the impact of local and state tobacco use prevention initiatives. Evaluation provides accountability and monitors whether program goals are achieved. In 1999, North Carolina Tobacco Prevention and Control Branch partnered with the NC Department of Public Instruction, Safe and Drug-Free Schools Program to conduct the CDC's *Youth Tobacco Survey* (*NC YTS*). This school-based survey of over 12,000 NC students provided the state with in-depth baseline information for NC. It measured achievement of ultimate outcomes such as reducing prevalence of tobacco use among youth as well as intermediate outcomes such as attitudes, beliefs, and behaviors (e.g. quit attempts).

A new Program Tracking System (PTS) has been developed by the TPCB to measure process and impact measures toward statewide objectives. This evaluation component provides feedback to the Branch's program. Surveillance and evaluation activities are excellent ways to decide how to target resources and demonstrate progress toward goals and use funds effectively.

Large scale surveys, such as the NC YTS and smaller ongoing surveys should continue as well as expand with similar surveys among adults and high risk populations. The goal is to measure program effectiveness in addition to outcome measures. The Youth Risk Behavior Survey (YRBS) measures the comprehensive risk taking behaviors among middle and high school students. The Division of Public Health conducts the Behavioral Risk Factor Surveillance Survey (BRFSS) to determine risk-taking behaviors among adults in North Carolina.

Many states work in conjunction with universities and colleges to implement and coordinate surveillance, evaluation and research activities. For example, the NC Division of Public Health collaborated with UNC School of Medicine to conduct special studies and to publish research that has advanced efforts regarding youth access to tobacco products and restaurants and family business policies on secondhand smoke.

SURVEILLANCE AND EVALUATION ACTIVITIES ARE EXCELLENT WAYS TO DECIDE HOW TO TARGET RESOURCES AND DEMONSTRATE PROGRESS TOWARD GOALS AND USE FUNDS EFFECTIVELY.

WORKING TOGETHER, the elements of this plan create a comprehensive program tailored for North Carolina to prevent and reduce the leading cause of premature death and disability in our state. The plan is based upon the essential elements of the Centers for Disease Control and Prevention (CDC) *Best Practices for Comprehensive Tobacco Control Programs.*

We stand at a crossroads—a unique point in time. Our knowledge of how to prevent death and disability caused by tobacco use has been building over the last decade. The results of successful state tobacco use prevention and control programs have shown that comprehensive, sustained, population-based strategies, combined with targeted media campaigns can reduce youth and adult tobacco use. These changes, if applied to North Carolina, can save valuable resources spent on health care costs and would spare the suffering of families who lose a loved one to a tobacco-related illness. An unprecedented opportunity lies before us to make a wise investment in a comprehensive tobacco control program that will bolster the personal and economic health of the citizens of North Carolina.

appendix

I. COMPREHENSIVE TOBACCO USE PREVENTION AND CONTROL STATE RESULTS

CALIFORNIA

Over a 10 year period

- ❏ Percent of smokers dropped from 25 percent to 18 percent
- ❏ 50 percent drop in cigarette consumption, actual number of packs smoked
- ❏ 33,300 lives saved by preventing heart disease
- ❏ 14 percent drop in lung cancer
- ❏ Almost all public places are smoke-free

FLORIDA

In less than two years (1998-2000)

- ❏ 40 percent drop among middle school students
- ❏ 18 percent drop among high school students
- ❏ 45 percent decline of any tobacco use by middle school students
- ❏ 17 percent decline of any tobacco use by high school students

MASSACHUSETTS

- ❏ Percent of smokers dropped from 22 percent in 1993 to 18 percent in 2000
- ❏ 40 percent drop in cigarette consumption (sales) (1992-2000)
- ❏ Pregnant smokers declined from 26 percent to 11 percent (more than 50 percent drop from 1990-1998)
- ❏ Drop in smokeless tobacco use from 18 percent to six percent
- ❏ 70 percent of public places are smoke-free—with no impact on restaurant business

ARIZONA

- ❏ By 1999, less than 19 percent of adults were smokers—a 21 percent reduction (since 1996)
- ❏ In 1995, Arizona increased state sales tax; since 1996, 23 percent of cigarette tax revenue funds tobacco education and prevention programs

Source: Centers for Disease Control and Prevention, 2001

OREGON

Results from 1997-1999

- ❏ 31 percent drop in percentage of 8th graders who smoke
- ❏ 17 percent drop in percentage of 11th graders who smoke
- ❏ 6.4 percent drop in percentage of adults who smoke
- ❏ 20 percent drop since 1997 in overall tobacco consumption

"NOT SINCE THE POLIO VACCINE HAVE WE HAD SUCH A TREMENDOUS OPPORTUNITY TO REDUCE DEATH AND DISABILITY IN THIS COUNTRY."

DR. DAVID SATCHER
U.S. SURGEON GENERAL

NORTH CAROLINA SCHOOL DISTRICTS WITH 100 PERCENT TOBACCO-FREE SCHOOL POLICIES, INCLUDING STUDENTS, STAFF AND VISITORS

As of printing March 2001, seven additional school districts have adopted a 100 percent tobacco-free school policy since 1999. This brings the total to 13 tobacco-free school districts. The school districts are:

ASHEVILLE CITY

CABARRUS COUNTY

CALDWELL COUNTY

CARTERET COUNTY

GUILFORD COUNTY

HENDERSON COUNTY

HERTFORD COUNTY

HICKORY CITY

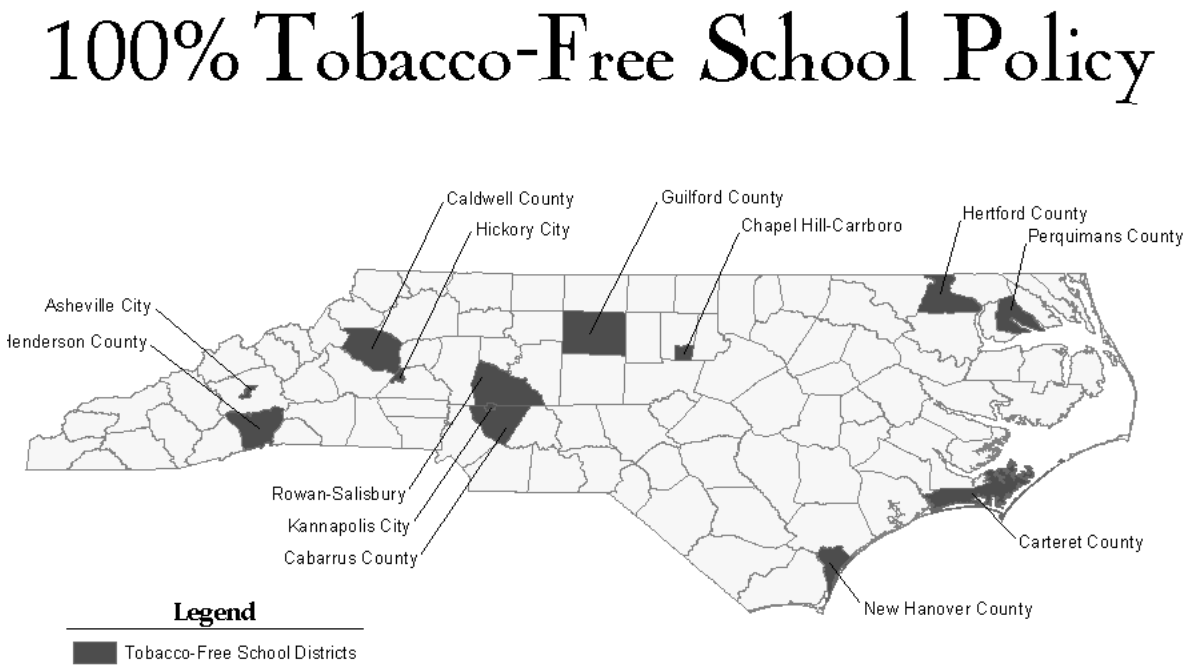
KANNAPOLIS CITY SCHOOLS

NEW HANOVER COUNTY

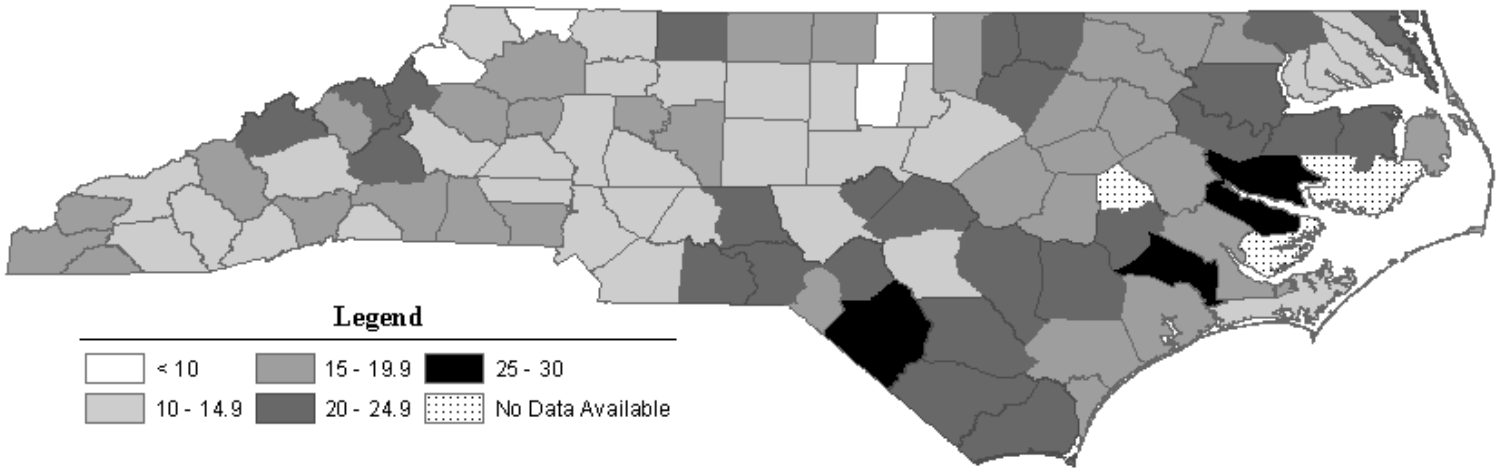
CHAPEL HILL-CARRBORO

PERQUIMANS COUNTY

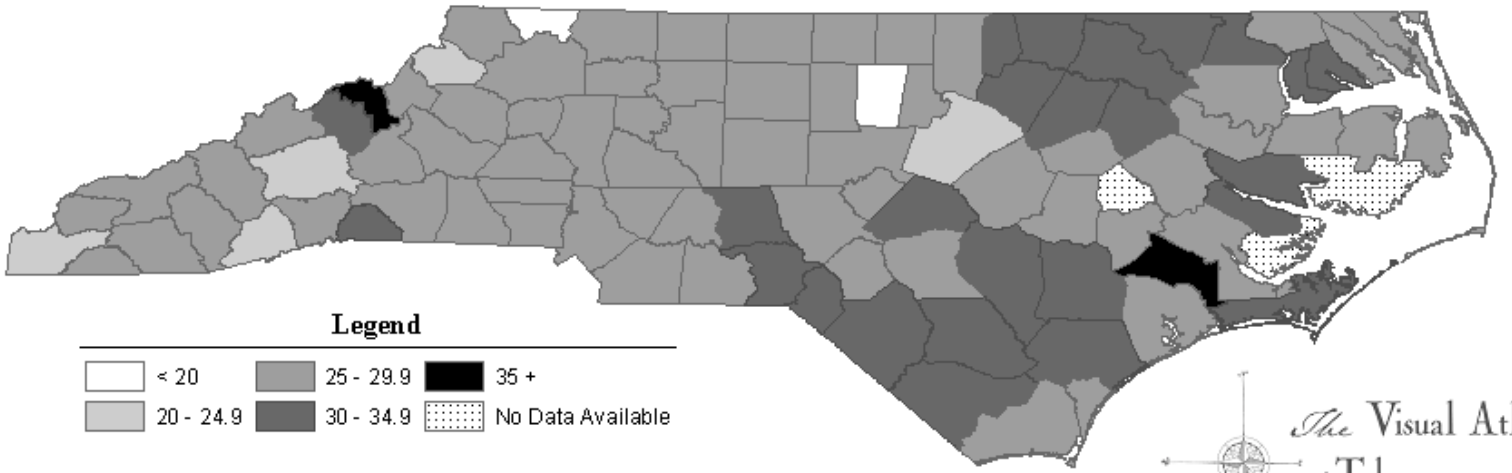
ROWAN-SALISBURY



Percent Current Cigarette Smokers Among NC Middle School Students



Percent of NC Middle School Students Living With Household Smokers



The Visual Atlas of Tobacco for North Carolina

Source: North Carolina School Asthma Survey, 1999-2000. Conducted by: Casey Herget, MSW,MPH, NC State Asthma Program Coordinator, NC Division of Public Health and Dr. Karin Yeatts, Department of Epidemiology, School of Public Health, UNC-CH

Map created by: School of Public Health, University of North Carolina at Chapel Hill, Kurt M. Ribisl, Ph.D., and Lisa E. Fastnaught

PERCENT OF MIDDLE SCHOOL STUDENTS WITH ANY SMOKERS IN HOUSEHOLD BY COUNTY

COUNTY	PERCENT
ALAMANCE	27.06
ALEXANDER	**25.53**
ALLEGHANY	18.00
ANSON	**28.69**
ASHE	29.98
AVERY	**29.69**
BEAUFORT	30.23
BERTIE	**28.27**
BLADEN	31.17
BRUNSWICK	**29.63**
BUNCOMBE	24.84
BURKE	**27.89**
CABARRUS	28.01
CALDWELL	**27.22**
CAMDEN	25.84
CARTERET	**30.28**
CASWELL	29.57
CATAWBA	**26.75**
CHATHAM	27.87
CHEROKEE	**22.90**
CHOWAN	30.52
CLAY	**27.59**
CLEVELAND	28.34
COLUMBUS	**31.40**
CRAVEN	27.63
CUMBERLAND	**27.26**
CURRITUCK	28.72
DARE	**28.29**
DAVIDSON	27.98
DAVIE	**26.43**
DUPLIN	31.01
DURHAM	**25.02**
EDGECOMBE	31.77
FORSYTH	**25.83**
FRANKLIN	31.02
GASTON	**25.81**
GATES	25.85
GRAHAM	**27.65**
GRANVILLE	29.27
GUILFORD	**26.63**
HALIFAX	30.40
HARNETT	**30.39**
HAYWOOD	28.83
HENDERSON	**28.67**
HERTFORD	30.59
HOKE	**28.79**
IREDELL	27.65
JACKSON	**29.75**
JOHNSTON	27.13
JONES	**39.20**
LEE	26.82
LENOIR	**29.67**
LINCOLN	28.92
MACON	**28.99**
MADISON	26.04
MARTIN	**29.98**
MCDOWELL	29.96
MECKLENBURG	**25.52**
MITCHELL	38.10
MONTGOMERY	**31.72**
MOORE	28.22
NASH	**30.19**
NEW HANOVER	25.63
NORTHHAMPTON	**30.40**
ONSLOW	29.32
ORANGE	**18.71**
PASQUOTANK	28.21
PENDER	**30.46**
PERQUIMANS	33.09
PERSON	**28.21**
PITT	27.40
POLK	**30.00**
RANDOLF	27.19
RICHMOND	**32.95**
ROBESON	33.67
ROCKINGHAM	**28.23**
ROWAN	26.70
RUTHERFORD	**29.49**
SAMPSON	31.37
SCOTLAND	**31.78**
STANLY	29.14
STOKES	**29.59**
SURRY	28.50
SWAIN	**27.23**
TRANSYLVANIA	22.99
TYRRELL	**28.44**
UNION	25.19
VANCE	**31.46**
WAKE	22.04
WARREN	**30.49**
WASHINGTON	28.42
WATAUGA	**22.53**
WAYNE	28.42
WILKES	**25.06**
WILSON	29.17
YADKIN	**29.27**
YANCEY	32.75

Source: North Carolina School Asthma Survey, 1999-2000. Conducted by: Casey Herget, MSW, MPH, NC State Asthma Program Coordinator, NC Division of Public Health and Dr. Karin Yeatts, Department of Epidemiology, School of Public Health, UNC-CH

PERCENT OF CIGARETTE SMOKING AMONG MIDDLE SCHOOL STUDENTS BY COUNTY

COUNTY	PERCENT
ALAMANCE	11.37
ALEXANDER	**18.12**
ALLEGHANY	6.12
ANSON	**22.50**
ASHE	11.01
AVERY	**22.22**
BEAUFORT	28.04
BERTIE	**22.46**
BLADEN	23.07
BRUNSWICK	**21.30**
BUNCOMBE	12.78
BURKE	**13.70**
CABARRUS	12.38
CALDWELL	**15.40**
CAMDEN	12.80
CARTERET	**14.57**
CASWELL	18.97
CATAWBA	**12.79**
CHATHAM	14.21
CHEROKEE	**17.30**
CHOWAN	13.27
CLAY	**19.65**
CLEVELAND	17.85
COLUMBUS	**22.55**
CRAVEN	18.16
CUMBERLAND	**13.29**
CURRITUCK	22.80
DARE	**15.69**
DAVIDSON	16.34
DAVIE	**17.02**
DUPLIN	22.20
DURHAM	**12.89**
EDGECOMBE	19.85
FORSYTH	**12.87**
FRANKLIN	20.43
GASTON	**15.46**
GATES	20.69
GRAHAM	**16.57**
GRANVILLE	17.80
GUILFORD	**10.99**
HALIFAX	15.55
HARNETT	**21.12**
HAYWOOD	16.32
HENDERSON	**16.12**
HERTFORD	16.60
HOKE	**23.31**
IREDELL	14.16
JACKSON	**12.20**
JOHNSTON	19.34
JONES	**26.70**
LEE	21.92
LENOIR	**22.18**
LINCOLN	12.08
MACON	**10.14**
MADISON	22.26
MARTIN	**23.39**
MCDOWELL	21.07
MECKLENBURG	**11.95**
MITCHELL	23.81
MONTGOMERY	**22.91**
MOORE	13.44
NASH	**17.59**
NEW HANOVER	18.27
NORTHHAMPTON	**17.58**
ONSLOW	16.19
ORANGE	**8.00**
PASQUOTANK	10.08
PENDER	**19.57**
PERQUIMANS	13.33
PERSON	**9.72**
PITT	17.41
POLK	**13.31**
RANDOLF	14.82
RICHMOND	**24.51**
ROBESON	28.47
ROCKINGHAM	**17.46**
ROWAN	12.99
RUTHERFORD	**17.52**
SAMPSON	22.09
SCOTLAND	**19.21**
STANLY	13.85
STOKES	**20.40**
SURRY	13.58
SWAIN	**11.94**
TRANSYLVANIA	11.76
TYRRELL	**24.55**
UNION	13.01
VANCE	**21.71**
WAKE	14.10
WARREN	**22.56**
WASHINGTON	20.11
WATAUGA	**6.99**
WAYNE	15.29
WILKES	**17.85**
WILSON	18.90
YADKIN	**12.36**
YANCEY	18.82

Source: North Carolina School Asthma Survey, 1999-2000. Conducted by: Casey Herget, MSW, MPH, NC State Asthma Program Coordinator, NC Division of Public Health and Dr. Karin Yeatts, Department of Epidemiology, School of Public Health, UNC-CH

THE LEAD CONTRIBUTORS WOULD LIKE TO THANK THE FOLLOWING WORKGROUP PARTICIPANTS:

Cathy ADELMAN	Health Promotion, Naval Hospital	Treatment/Cessation
Kate AHLPORT	Moses Cone Wesley Long Community	Treatment/Cessation
Kathy ANDERSEN	Nutrition, Education, and Training Program	Tobacco Free Schools
Angela BATES	Onslow County ASSIST Coalition	Community Based
Karl BAUMAN	UNC School of Public Health	Evaluation/Surveillance
Andrea BAZAN MANSON	El Pueblo	Diversity
Barry BLICK	Catawba County Public Health Department	Community Based
Kathy BLUE	NC Tobacco Prevention and Control Branch	Evaluation/Surveillance
Erin BRAASCH	Buncombe County ASSIST Coalition	Community Based
Margaret BRAKE	NC Substance Abuse Services	Tobacco Free Schools
Missy BRAYBOY	NC Commission of Indian Affairs/Health Committee	Diversity, Community Based
Donna BREITENSTEIN	NC Comprehensive School Health Training	Tobacco Free Schools
Chuck BRIDGER	American Cancer Society, Southeast Division	Tobacco Free Schools, Media Treatment/Cessation, Diversity
Jeff BRIGHT	American Cancer Society	Media
Dorothea BROCK	Healthy Schools, Department of Public Instruction	Tobacco Free Schools
Tynetta BROWN	Health Promotion Section, PAN Unit	Media
Deborah BRYAN	American Lung Association	Treatment/Cessation
Cheryl BYERS CALOGERAKIS	Area Health Education Centers	Treatment/Cessation
Sarah CARTER	Safe and Drug Free Schools	Tobacco Free Schools
DeAnne CHRYST	New Hanover/Brunswick County ASSIST Coalition	Community Based
Traci CLARK	Hi-Top ASSIST Coalition	Diversity, Community Based
Frank COLLINS	Recovery Network/Rnet Health, Inc.	Media
Sandra COLT	NC Tobacco Prevention and Control Branch	Community Based
Angela CONNOR	FirstHealth of the Carolinas	Treatment/Cessation
Sarah COX	NC Prevention Partners	Treatment/Cessation
George CRAWFORD	Mecklenburg County Coalition	Diversity, Media, Community Based
Sue CRUMPSTON	High Point Regional Health System	Treatment/Cessation
Leah DEVLIN	NC Health Promotion, Disease Prevention	Community Based
Nancy DIXON	Safe and Drug Free Schools, Forsyth County	Tobacco Free Schools
Judy ELLIOT	NC Health Promotion, Disease Prevention	Community Based
Kim GASKINS	Tobacco Cessation	Treatment/Cessation
Mary GILLETT	Guilford County ASSIST	Tobacco Free Schools, Community Based
Adam GOLDSTEIN	UNC School of Medicine	Media
Christina GORDON	American Cancer Society	Media
Chandra GREEN	Craven/Pamlico County ASSIST Coalition	Community Based
Deanna HALE-HOLLAND	Coastal Horizons Center, Inc	Media
Kathy HARRELSON	Council for Women	Diversity
Lorna HARRIS	NC A&T University/HBCU Health Promotion Alliance	Diversity
Faye HAUPT	High Country ASSIST Coalition	Community Based
Sandra HEADEN	National African American Tobacco Prevention Network	Diversity, Media

Jancie HORNER	Medical Review of NC	Treatment/Cessation
Ann HOUSTON	NC Tobacco Prevention and Control Branch	Media
Delmonte P. JEFFERSON	NC Tobacco Prevention and Control Branch	Diversity
Kathy JORDAN	Safe and Drug Free Schools	Tobacco Free Schools
Betsy LAFORGE	Doctors Health Plan	Treatment/Cessation
Betsy LEVITAS	Cancer Information Services	Diversity, Media
Brett LOCKLEAR	NC Commission of Indian Affairs	Diversity
Sally HERNDON MALEK	NC Tobacco Prevention and Control Branch	Treatment/Cessation, Community Based
Jim MARTIN	NC Division of Public Health	Diversity, Tobacco Free Schools, Treatment/Cessation, Evaluation/Surveillance
Kathleen MCCANN WEBSTER	Schools Consultant	Tobacco Free Schools
Tim MCGLOIN	UNC School of Public Health	Media
Cathy MELVIN	Sheps Center for Health Services, UNC	Treatment/Cessation
Sylvia MENTIS	Council on Adolescents of Catawba County	Diversity, Media
Laurie METTAM-RUDE	NC Tobacco Prevention and Control Branch	Diversity
Meg MOLLOY	NC Prevention Partners	Treatment/Cessation
Thea MONET	Old North State Medical Society	Diversity
Karen MORANT	African American Action Team	Diversity, Media
Anne MURR	Northwest High School	Tobacco Free Schools
Pat NOFSINGER	Independence High School	Tobacco Free Schools
Tricia PARISH WARD	Division of Public Health, Women's Health	Treatment/Cessation
Marguerite PEEBLES	Alternative and Safe Schools, Dept. of Public Instruction	Tobacco Free Schools
Barbara PULLEN-SMITH	Office of Minority Health	Diversity
Amy QUESINBERRY	Regional School Nurse Consultant	Tobacco Free Schools
Terry QUINN	Pitt County ASSIST Coalition	Community Based
Kenneth RAY	NC Tobacco Prevention and Control Branch	Tobacco Free Schools, Diversity
Felicia LYTLE-REID	4-H Youth Development, Wake County	Community Based
Kurt RIBISL	UNC School of Public Health	Diversity, Media, Evaluation/Surveillance
Richard ROSEN	NC Medical Society	Treatment/Cessation
Lisa SARASOHN	Survivors And Victim's Empowered	Tobacco Free Schools
Dan STALEY	Appalachian District Public Health Department	Community Based
Karen STALLINGS	Area Health Education Centers	Treatment/Cessation
Gregg STAVE	GlaxoSmithKline	Treatment/Cessation
Crystal TEDDER	Doctor's Health Plan, Inc.	Media
Lisa THOMAS	Health Action Council of NC	Tobacco Free Schools
Vernice THOMAS	Safe and Drug Free Schools, Burlington	Tobacco Free Schools
Anna WOOD	NC Tobacco Prevention and Control	Community Based
Jennifer WOODWARD	Durham County Health Department	Tobacco Free Schools
Margaret WATKINS	Appalachian District Health Department	Community Based

vision 2010
NORTH CAROLINA

NCPH
North Carolina Public Health

dhhs

For more information contact: Tobacco Prevention and Control Branch • Division of Public Health • North Carolina Department of Health and Human Services • 1915 Mail Service Center • Raleigh, NC 27699-1915 • 919.733.1881.